Texas Department of Aging
and Disability Services

CBA Semiannual Nursing Assessment

Form 3751
January 2012

Applicant/Individual Name	Medicaid No.	SSN - -	Date of Birth	Date of Assessment
Semiannual ☐ 1 ☐ 2	Applicant/Individual Address			

NOTE: Data elements from OASIS are identified with the OASIS code. Data elements from the Minimum Data Set Home Care (MDS-HC) will be numbered as in the MDS-HC instrument.

I. CBA SIGNIFICANT CHANGES IN LAST 90 DAYS AS REPORTED BY INDIVIDUAL

☐ **1-Hospitalizations** ☐ **3-Functional Decline** ☐ **5-Caregiver Status Change** ☐ **7-Move to New Address**
☐ **2-New Diagnosis(es)** ☐ **4-Loss of Loved One** ☐ **6-Fall/Accident** ☐ **8-Other:** _____

II. MDS-HC SECTION CC: REFERRAL

2. Reason for Referral:

☐ **1-Post Hospital Care** ☐ **2-Community Chronic Care** ☐ **3- Home Placement Screen** ☐ **4-Eligibility for Home Care (CBA)**
☐ **5-Day Care** ☐ **6-Other:** _____

4. Living Arrangements at Time of Assessment

☐ **1-Lives Alone** ☐ **2-With Spouse/Significant Other** ☐ **3-With Other Family Member** ☐ **4-With a Friend**
☐ **5-With Paid Help (other than home care agency staff)** ☐ **6-In Group Setting with Non-Relatives** ☐ **7-Other:** _____

III. MDS-HC SECTION O: ENVIRONMENTAL

1. Home Environment: Check any of the following that make home environment hazardous or uninhabitable. (If none apply, check "None of the Above;" if temporarily in institution, base assessment on home visit.)

☐ **1-Lighting in Evening (including inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors)**
☐ **2-Flooring and Carpeting (e.g. holes in the floors, electric wires where individual walks, scatter rugs)**
☐ **3-Bathroom and Toilet Room (e.g. non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet)**
☐ **4-Kitchen (e.g. dangerous stove, inoperative refrigerator, infestation by rats/bugs)**
☐ **5-Heating and Cooling (e.g. too hot in summer, too cold in winter, wood stove in a home with an asthmatic)**
☐ **6-Personal Safety (e.g. fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street)**
☐ **7-Access to Home (e.g. difficulty entering/leaving home)** ☐ **8-Access to Rooms in House (e.g. unable to climb stairs)** ☐ **9-None of These**

2. Living Arrangement

A. As compared to 90 days ago, individual now lives with other persons (e.g. moved in with another or other person moved in with individual).
☐ **0-No** ☐ **1-Yes**

B. Individual or primary caregiver feels that the individual would be better off in another living environment.
☐ **0-No** ☐ **1- Individual Only** ☐ **2-Caregiver Only** ☐ **3- Individual and Caregiver**

3. MO 300 – Current Residence

☐ **1- Individual's Owned or Rented Residence (house, apartment, or mobile home owned or rented by individual/couple/significant other)**
☐ **2-Family Member's Residence** ☐ **3-Boarding Home or Rented Room** ☐ **4-Assisted Living Facility or Personal Care Home**
☐ **5-Adult Foster Home** ☐ **6-Other:** _____

4. MO 310 – Structural Barriers

☐ **0-None**
☐ **1-Stairs Inside Home Which Must Be Used by the Individual (e.g. to get to toileting/sleeping/eating areas)**
☐ **2-Stairs Inside Home Which are Used Optionally (e.g. to get to laundry facilities)**
☐ **3-Stairs Leading from Inside House to Outside** ☐ **4-Narrow or Obstructed Doorways**

5. MO 320 – Safety Hazards

- ☐ 0-None
- ☐ 1-Inadequate Floor/Roof/Windows
- ☐ 2-Inadequate Lighting
- ☐ 3-Unsafe Gas/Electric Appliance
- ☐ 4-Inadequate Heating
- ☐ 5-Inadequate Cooling
- ☐ 6-Lack of Safety Devices
- ☐ 7-Unsafe Floor Coverings
- ☐ 8-Inadequate Stair Railings
- ☐ 9-Improperly Stored Hazardous Materials
- ☐ 10-Lead-Based Paint
- ☐ 11-Other: _____

6. MO 000 – Sanitation Hazards

- ☐ 0-None
- ☐ 1-No Running Water
- ☐ 2-Contaminated Water
- ☐ 3-No Toileting Facilities
- ☐ 4-Outdoor Toileting Facilities Only
- ☐ 5-Inadequate Sewage Disposal
- ☐ 6-Inadequate/Improper Food Storage
- ☐ 7-No Food Refrigeration
- ☐ 8-No Cooking Facilities
- ☐ 9-Insects/Rodents Present
- ☐ 10-No Scheduled Trash Pick-Up
- ☐ 11-Cluttered/Soiled Living Area
- ☐ 12-Other: _____

IV. MDS-HC SECTION F: SOCIAL FUNCTIONING

1. **Changes in Social Activities:** In the past 180 days (or since last assessment if less than 180 days ago), has there been a decline in the individual's level of participation in social, religious, occupational or other preferred activities?

   ☐ 0-No Decline ☐ Decline, but individual not distressed ☐ Decline, individual distressed

2. **Isolation:**

   A. How long is the individual alone during the day (morning and afternoon)?

   ☐ 0-Never or Seldom ☐ 1-About One Hour ☐ 2-Long Periods of Time (e.g. all morning) ☐ 3-All of the Time

   B. Does the individual say or indicate that he/she feels lonely?

   ☐ 0-No ☐ 1-Yes

V. MDS-HC SECTION G: INFORMAL SUPPORT SERVICES

1. **Two Key Informal Helpers (if applicable):**

A. Name of Primary Helper (Last, First)	B. Lives with Individual	C. Relationship to Individual
	☐ 0-Yes ☐ 1-No ☐ 3-NA	☐ 0-Child/Child-in-law ☐ 1-Spouse ☐ 2-Other Relative ☐ 3-Friend/ Neighbor
D. Name of Secondary Helper (Last, First)	E. Lives with Individual	F. Relationship to Individual
	☐ 0-Yes ☐ 1-No ☐ 3-NA	☐ 0-Child/Child-in-law ☐ 1-Spouse ☐ 2-Other Relative ☐ 3-Friend/ Neighbor

2. **Caregiver Status (check all that apply)**

   - ☐ A-A caregiver is unable to continue in caring activities (e.g. decline in health of caregiver makes it difficult to continue).
   - ☐ B-Primary caregiver is not satisfied with support received from family and friends (e.g. other children of individual).
   - ☐ C-Primary caregiver expresses feelings of distress, anger or depression.
   - ☐ D-None of the above.

3. **MO 370 - How often does the individual receive assistance from the primary caregiver?**

   ☐ 1-Several Times During the Day and Night ☐ 2-Several Times During the Day ☐ 3-Once Daily ☐ 4-Three or More Times per Week ☐ 5-One or Two Times per Week ☐ 6-Less Often than Weekly ☐ 7-Unknown

4. **MO 380 - Type of Primary Caregiver Assistance**

   - ☐ 1-ADL Assistance (e.g. bathing, dressing, toileting, bowel/bladder, eating/feeding)
   - ☐ 2-IADL Assistance (e.g. meds, meals, housekeeping, laundry, telephone, shopping, finances)
   - ☐ 3-Environmental Support (housing, home maintenance)
   - ☐ 4-Psychosocial Support (socialization, companionship, recreation)
   - ☐ 5-Advocates or Facilitates Individual 's Participation in Appropriate Medical Care
   - ☐ 6-Financial Agent, Power of Attorney, or Conservator of Finance
   - ☐ 7-Health Care Agent, Conservator of Person, or Medical Power of Attorney
   - ☐ 8-Nursing Tasks

VI. MDS-HC SECTION P: SERVICE UTILIZATION

1. **Formal Care provided by TPR's (other than CBA) at time of assessment** (minutes rounded to even 10 minutes). Indicate the extent of care or care management in the last 14 days (or since last assessment if less than 14 days):

	(A) DAYS	(B) HOURS	(C) MINUTES
A. **Personal Assistance Services**			
B. **Nursing Services**			
C. Homemaking Services			
D. Meals			
E. Volunteer Services			
F. Physical Therapy			
G. Occupational Therapy			
H. Speech Therapy			
I. Respiratory Therapy			
J. Day Care or Day Hospital			
K. Social Worker in Home			
L. Hospice			
M. **Other:**			

2. **Management of Equipment** (in the last 14 days) – **Enter the applicable codes in the appropriate boxes.**

0=Not Used 1=Managed on Own 2=Managed on Own if Laid Out w/Verbal Reminders 3=Partially Performed by Others 4=Fully Performed by Others

A. Oxygen: ☐ **B. IV:** ☐ **C. Catheter:** ☐

3. **Overall Change in Care Needs** – Indicate if individual's overall self-sufficiency has changed significantly in the past 90 days (or since last assessment if less than 90 days).

☐ **0-No Change** ☐ **1-Improved–receives fewer supports** ☐ **2-Deteriorated–receives more support**

4. **Trade-Offs** – During the past month has the individual, because of limited funds, made trade-offs in purchasing any of the following: prescribed medications, sufficient home heat, necessary physician care, adequate food, home care?

☐ **0-No** ☐ **1-Yes**

VII. MDS-HC SECTION H: PHYSICAL FUNCTIONING (self-performing or instrumental [IADL] and personal [ADL] act of daily living)

1. **IADL Self Performance** (functioning in routine activities around the home or in the community during last seven days)

A. IADL Self Performance Code – Use the following codes to indicate individual's performance during the past seven days:

0=Independent (did on own) **1=Some Help (help some of the time)** **2=Full Help (performed with help all of the time)** **3=By Others (performed by others)** **8=Activity Did Not Occur**

B. IADL Difficulty Code – Indicate how difficult is it (or would be) for individual to perform the following activities:

0=No Difficulty **1=Some Difficulty** (needs some help, is very slow, fatigues) **2=Great Difficulty** (little or no involvement in the activity)

ACTIVITY	SELF PERFORMANCE	DIFFICULTY
a. Meal Preparation – How meals prepared (e.g. planning meals, cooking, assembling ingredients, setting out food/utensils).		
b. Ordinary House Work – How work around the house is performed (doing dishes, dusting, making bed, tidying up, laundry).		
c. Managing Finances – How finances are managed (paying bills, balancing checkbook, household expenses balanced).		
d. Managing Medications – How medications are managed (remembering to take meds, opening bottles, taking correct dosages, giving injections, applying ointments).		
e. Telephone Use – How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed).		
f. Shopping – How shopping is performed for food and household items (selecting items, managing money).		
g. Transportation – How individual travels by vehicle (e.g. gets to places beyond walking distance).		

2. Primary Modes of Locomotion

A. Indoors
☐ **0-No Assistive Device** ☐ **1-Cane** ☐ **2-Walker/Crutch** ☐ **3-Scooter (e.g. Amigo)** ☐ **4-Wheelchair** ☐ **5-Activity Does Not Occur**

B. Outdoors
☐ **0-No Assistive Device** ☐ **1-Cane** ☐ **2-Walker/Crutch** ☐ **3-Scooter (e.g. Amigo)** ☐ **4-Wheelchair** ☐ **5-Activity Does Not Occur**

3. Stair Climbing: Indicate how individual went up and down stairs during the past seven days (e.g. single or multiple steps, using handrail as needed). If individual did not go up and down stairs, code individual's capacity for stair climbing.

☐ **0-Up and Down Stairs Without Help**
☐ **1-Up and Down Stairs With Help**
☐ **2-Not Go Up and Down Stairs – could do without help**
☐ **3-Not Go Up and Down Stairs – could do with help**
☐ **4-Not Go Up and Down Stairs – no capacity to do it**
☐ **8-Unknown (did not climb stairs; assessor unable to judge whether capacity exists**

*** 4. Stamina**

A. In a typical week, during the past 30 days, how often the individual usually went out of the house or building (even for a short
☐ **0-Every Day** ☐ **1-Two to Six Days a Week** ☐ **2-One Day a Week** ☐ **3-No Days (did not go out)**

B. Indicate how many hours of physical activity individual had during past seven days (e.g. walking, cleaning house, exercise).
☐ **0-Two or More Hours** ☐ **1- Less than Two Hours**

5. Functional Potential

☐ **A-Individual believes he/she is capable of increased functional independence (ADL, IADL, mobility).**
☐ **B-Caregivers believe individual is capable of increased functional independence (ADL, IADL, mobility).**
☐ **C-Good prospects of recovery from cu rrent disease or conditions; improved health status expected.**
☐ **D-None of the Above**

VIII. MDS-HC SECTION K: HEALTH CONDITIONS AND PREVENTIVE HEALTH MEASURES

1. Preventive Health (check all that apply; past two years)

☐ **A-Blood Pressure Measured** ☐ **C-Breast Exam or Mammography (if female)** ☐ **E-Physician's Exam/Diagnostics**
☐ **B-Influenza Vaccination** ☐ **D-Pneumovax** ☐ **F-None**

2. Problem Conditions (check all conditions present on at least two of the past seven days)

☐ **A-Diarrhea** ☐ **D-Difficulty Urinating or Urinating 3 or more times at night** ☐ **G-None of These**
☐ **B-Fever** ☐ **E-Loss of Appetite** ☐ **H-Other:**
☐ **C-Vomiting** ☐ **F-Dizziness**

3. Problem Conditions in Last Week (check all present at any time during past seven days)

PHYSICAL HEALTH
☐ **A-Change in Sputum Production** ☐ **D-Dizziness or Lightheadedness** ☐ **G-Other:**
☐ **B-Chest Pain at Exertion or Chest Pain/Pressure at Rest** ☐ **E-Edema**
☐ **C-Constipation in Four of Past Seven Days** ☐ **F-Shortness of Breath** ☐ **H-None**

MENTAL HEALTH
☐ **I-Delusions** ☐ **J-Hallucinations** ☐ **K-None of These** ☐ **L-Other:** _____

4. Pain (during the past seven days)

A. Frequently complains/shows evidence of pain: ..... ☐ **0-No Pain (skip to 4.e.)** ☐ **1-Pain Less than Daily** ☐ **2-Pain Daily**
B. Is pain usually intense? ..... ☐ **0-No** ☐ **1-Yes**
C. Does pain disrupt usual activities?... ☐ **0-No** ☐ **1-Yes**
D. What is character of the pain? ..... ☐ **0-No Pain** ☐ **1- Localized-Single Site** ☐ **2-Multiple Sites**
E. Is pain controlled by medication?..... ☐ **0-No Pain** ☐ **1-Medication Offered No Control** ☐ **2-Partially or Fully Controlled by Medication**

*** An NF risk item.**

* **5. Falls –** How many times, in the past seven days, has individual fallen? ("0" if none; if more than 9, enter "9") .....

6. Danger of Fall

A. Does individual have an unsteady gait? ..... ☐ **0-No** ☐ **1-Yes**

B. Does individual limit going outdoors due to fear of falling (e.g. stopped using bus, goes out only with others)? ..... ☐ **0-No** ☐ **1-Yes**

7. Life Style (drinking/smoking)

A. In the past 90 days (or since last assessment if less than 90 days), did individual feel the need, or was individual by others to cut down on drinking, or were others concerned with individual's drinking? ..... ☐ **0-No** ☐ **1-Yes**

B. In the past 90 days (or since last assessment if less than 90 days), did individual need a drink the first thing in the morning to "steady nerves" (i.e. "eye opener") or has individual been in trouble because of drinking? . ☐ **0-No** ☐ **1-Yes**

C. For a typical week in the past month, enter the number of days (0 - 7) individual had one or more drinks: .....

D. On days individual drinks, enter number of drinks usually consumed per day ("0" for no drinks; "9" for 9 or more): .....

E. Does individual smoke or chew tobacco daily? ..... ☐ **0-No** ☐ **1-Yes**

8. Health Status Indicators

☐ **A-Individual feels he/she has poor health (when asked).**

☐ **B-Individual has conditions/diseases that make cognition, ADL, mood, or behavior patterns unstable (fluctuations, precarious, or deteriorating).**

☐ **C-Individual has experienced a flare-up of a recurrent or chronic problem.**

☐ **D-Treatment has changed in the past 30 days (or since last assessment if less than 30 days) because of a new acute episode or condition.**

☐ **E-Prognosis of less than six months to live (e.g. physician has told individual or individual's family that individual has end-stage disease).**

☐ **F-None of the Above**

9. Other Status Indicators

☐ **A-Individual is fearful of a family member or caregiver.**

☐ **B-Individual has unusually poor hygiene.**

☐ **C-Individual has unexplained injuries, broken bones, or burns.**

☐ **D-Individual has been neglected, abused, or mistreated.**

☐ **E-Individual has been physically restrained (e.g. limbs restrained, use of bed rails, constrained to chair when sitting).**

☐ **F-None of the Above**

IX. RISK FACTORS (Identification and Scoring) **– This Applicant/Individual:**

1. has a history of nursing facility placement within the last five years? ..... ☐ **0-No** ☐ **1-Yes**
2. has a neurological diagnosis of (check all that apply): ..... ☐ **0-No** ☐ **1-Yes**

☐ **A-Alzheimer's Disease** ☐ **B-Dementia (other than Alzheimer's)** ☐ **C-Head Trauma** ☐ **D-Multiple Sclerosis** ☐ **E- Parkinsonism**

3. goes out of his residence one or fewer days a week? ..... ☐ **0-No** ☐ **1-Yes**
4. has a history of falling two or more times in the past 180 days? ..... ☐ **0-No** ☐ **1-Yes**
5. required hands-on guidance or physical assistance on three or more occasions during the last seven days to accomplish any of the following tasks: (check all that apply) ..... ☐ **0-No** ☐ **1-Yes**

☐ **A- Dressing** – putting clothes on and taking clothes off.

☐ **B-Personal Hygiene –** combing hair, brushing teeth, shaving, applying makeup, washing hands/face and perineum. (Excludes baths and showers.)

☐ **C- Eating –** taking in food by any method, including tube feedings.

☐ **D-Toilet Use** – using toilet, bedpan or urinal, transferring on/off toilet, cleaning self after toilet use, changing pad or managing special devices required (ostomy or catheter) or adjusting clothes.

Or, **ANY** assistance, including supervision, in:

☐ **E- Bathing** – includes shower, full tub or sponge bath. (Exclude washing back or hair.)

*** An NF risk item.**

6. has multiple episodes of urinary incontinence daily? ☐ **0-No** ☐ **1-Yes**
7. had a functional decline in the last 90 days? ☐ **0-No** ☐ **1-Yes**

If yes; A. When did functional decline occur?	B. What was the functional decline?
C. Document rationale for identified response:	

X. MDS-HC SECTION L: NUTRITION/HYDRATION STATUS

1. Weight Change – Has there been weight loss of 5% or more in past 30 days or 10% or more in past 180 days? ☐ **0-No** ☐ **1-Yes**

2. Consumption

A. In at least four of the past seven days, did individual eat one or fewer meals? ☐ **0-No** ☐ **1-Yes**

B. In the past three days, has there been a noticeable decrease in the amount of food or fluid that is usually consumed? ☐ **0-No** ☐ **1-Yes**

C. Has the individual refused all/almost all fluids during last three days? (insufficient fluids) ☐ **0-No** ☐ **1-Yes**

3. Nutritional Treatments – Enter the number of days of formal care received in the past week:

A. Intravenous or Infusion Therapy–Hydration (not including TPN) ☐

B. Fluids by Mouth ☐

C. Parenteral Nutrition (TPN or lipids) ☐

D. Enteral (tube feeding) ☐

Comments:

RN Name (please type or print)	Telephone No.

Signature-RN

Date